Community Mental Health Association of Michigan

Written comments for the House Health Policy Committee
September 22, 2022

Chairman Kahle and Members of the Committee:

My name is Alan Bolter, Associate Director of the Community Mental Health Association of Michigan (CMHA). Our association represents Michigan's public mental health system which includes the 46 community mental health boards, 10 Prepaid Inpatient Health Plans, and over 100 provider organizations that deliver mental health, substance use disorder, and developmental disabilities services in every community across the state.

Thank you for your interest in this important topic. While we certainly appreciate and applaud Rep. Filler's passion for this issue, we do have several concerns regarding HB 6355.

- HB 6355 is a solution without a problem. **The most recent MDHHS-published MMBPIS Report for state-wide performance on this measure #1 is 98.59% completion within 3 hours for adults and 98.77% for children.** The system of CMHs and PIHPs have exceeded the required standard of 95% for years. The three-hour requirement for pre-screens has long been the expected contractual standard for the public mental health system. HB 6355 only codifies it into statute and adds intrusive terms and conditions.

- The example used as basis for the need for the statute refers to a 42-day emergency department boarding of a 16-year-old with an autism spectrum disorder. While regrettable, tragic, and unfortunately all too common that event had nothing to do with the speed of the pre-screen medical necessity determination process; the problem in that instance and the vast majority of similar situations was lack of placement options for public behavioral health patients.

- The real problem which CMHs and PIHPs and others have pointed out for years is too few private and state hospital inpatient psychiatric beds and too few alternatives such as Crisis Stabilization, Crisis Residential and semi-secure Crisis Residential facilities. State hospitals have been taking beds offline due to inability to staff and per MDHHS a high preponderance of staff Leaves and thus vacancies without an ability to fill those positions. Private inpatient psychiatric hospitals and alternatives have also struggled with staffing for years. The direct care wage funds infusion has helped but needs to be directly built into the PIHP capitation payments and not subject to legislative action and the resultant uncertainty for PIHPs, CMHSPs, Provider and Staff.

- Another documentable problem is the too common inpatient psychiatric hospital refusals to admit with such statements as "inappropriate for milieu," "previously left against medical advice," "behaviorally disordered," "medically fragile," "too high acuity," and the like. Placements for persons with Intellectual and Developmental Disorders with or without co-occurring serious mental illness or serious emotional disturbance are particularly challenging.

- Permitting persons not authorized by the CMHSPs and PIHPs to make medical necessity decisions whether to their own facility or another 1. Is contrary to Medicaid Provider Manual, 2. Is contrary

to PIHP-MDHHS Specialty Supports and Services Contract, 3. Is arguably in violation of federal Medicaid managed care regulations on delegation of functions, 4. Opens the hospitals to financial liability for the services they authorize, and 5. Will certainly create Payer Disputes for hospitals and the attendant administrative burdens.

    - Further the process violates the letter and spirit of conflict free case management also known and Conflict Free Access and Planning.

    - HB 6355 could raise potential scope of practice and state licensure issues if it allows other professionals who are not currently qualified or licensed to offer a behavioral health diagnosis.

- While HB 6355 claims to make the process "more efficient" it will in fact burden the process with time-keeping, clock-watching and probable differential decisions resulting in client confusion, client grievances and appeals, and administrative agency to agency payment complications and conflicts. It also obligates a CMH and/or PIHP to make payment to a hospital they have no pre-screen Contract with; public funds cannot flow without a written contract.

- The bill reads as if the person served has free reign decision authority over which hospital they choose (rarely are there two or more options) and seems to bind both PIHPs and hospitals to that persons' decision.

- It is stated by proponents of the Bill that "This legislation should help shorten the *difficult wait times* ***between the evaluation and beginning services***" that rationale explicitly says the "problem" is the period "between the evaluation and the services," a different problem with different solutions underway on many fronts.

- Logistically how will the start and stop times of the three-hour clock occur and be communicated properly? How will payers, patients and referral sources be informed.

For the reasons stated above CMHA opposes HB 6355 and respectfully requests that it not be approved by this committee. Again, thank you for your time and consideration of our remarks.

Respectfully submitted,

Alan Bolter
Associate Director